SPECIAL BULLETIN
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Missouri MEDICAID Bulletin

INDEX **PAGE**

MC+ CONTRACTS AWARDED FOR WESTERN MC+ REGION

New contracts have been awarded for the Western MC+ Region with an effective date of February 1, 1999. The Western MC+ Region is composed of the following counties: Cass, Clay, Henry, Jackson, Johnson, LaFayette, Platte, Ray and St. Clair. (Henry and St. Clair were added to the Western MC+ Region effective February 1, 1999.)

WESTERN MC+ REGION HEALTH PLANS

The following health plans will provide services for the Western Region MC+ program effective February 1, 1999:

BLUE-ADVANTAGE+ PLUS
2301 Main Street
Kansas City, MO 64141
Provider Relations:
(800) 892-6048
Fax: (816) 395-3811

FIRSTGUARD
3801 Blue Parkway
Kansas City, MO 64130
Provider Relations:
(888) 828-5698
Fax: (816) 922-7243

FAMILY HEALTH PARTNERS
215 W. Pershing Road, 6th Floor
Kansas City, MO 64141
Provider Relations:
(800) 347-9363
Fax: (816) 471-1832

HEALTHNET
2300 Main Street, Ste. 700
Kansas City, MO 64108
Provider Relations:
(800) 468-1442 Ext. 4333
Fax: (816) 221-7457

EXPANDED BENEFIT PACKAGE FOR WESTERN MC+ REGION

The benefit package under the Western MC+ Region has been expanded to include additional services for adults.

In addition to the services currently covered under MC+, the following services are included as a

benefit for MC+ enrollees* in the Western MC+ Region effective **February 1, 1999.**

- Adult day health care for adults age 18 and over;
- Basic personal care and advanced personal care for adults age 21 and over;
- Dental services for adults age 21 and over, excluding orthodontics;
- Hearing aid and related services for adults age 21 and over;
- Medically necessary optical services for adults age 21 and over;

* These services may be limited based on the enrollee's eligibility group. Refer to Special Bulletin Vol. 21, No. 4, dated January 22, 1999.

Refer to Special Bulletin Vol. 19. No. 2, dated September 26, 1996 for a listing of other MC+ benefits. Note: CSTAR services and coverage of protease inhibitors [pharmacy products] are no longer MC+ benefits and may be obtained on a fee-for-service basis.

Recipients who are enrolled in the MC+ program must access their health care services through their health plan for MC+ benefits. Medicaid enrolled providers who provide services covered as an MC+ benefit to a Medicaid recipient will not receive direct reimbursement from the State for services furnished while the recipient is enrolled in an MC+ health plan. Medicaid enrolled providers who wish to provide services for MC+ enrollees must contact the health plans for participation agreements.

The MC+ enrollee must be told in advance by a non-health plan Medicaid provider that the MC+ enrollee is able to receive the service from the health plan for no charge. If the MC+ enrollee wishes to receive the service from the non-health plan provider, the recipient or guardian must sign a statement prior to receiving the service that he or she has been informed that the service is available through the health plan but is being furnished by the non-health plan provider and he/she is willing to pay for the service as a private pay patient.

MRDD WAIVER SERVICES

Individuals who are in the MRDD waiver and who are eligible for inclusion in an MC+ health plan have been included in the Missouri Managed Care Program in the Western Missouri MC+ region only. An individual who is an MC+ health plan enrollee and becomes eligible for the MRDD waiver no longer has to opt out of the health plan in order to participate in the MRDD waiver. Home and community-based waiver services for persons in the Mentally Retarded and Developmental Disabilities (MRDD) waiver are carved out of the MC+ program. All other Medicaid covered services, unless specifically excluded, are the responsibility of the MC+ health plan for MRDD waiver clients enrolled in MC+.

Each person in the MRDD waiver has a service coordinator in the Department of Mental Health (DMH), Division of Mental Retardation and Developmental Disabilities (DMRDD) regional center. The service coordinator is responsible for case managing and coordinating waiver services for the individual.

The DMH service coordinator and the MC+ health plan case manager or primary care provider must collaborate on behalf of the client to insure coordinated care, access to care, and to avoid duplication of services.

Medically necessary physical therapy, occupational therapy, and speech therapy and counseling services which are covered in the MRDD waiver will be the responsibility of the MC+ health plan if the recipient is under the age of 21. These services are currently covered under the Healthy Children and Youth (HCY) program outside of the waiver. Medically necessary services that are covered under the Medicaid program for adults will be the responsibility of the MC+ health plan. These services are speech therapy when it is required for adaptive training for an artificial larynx, and occupational therapy for adaptive training for orthotic device or prosthesis, and physical therapy. Counseling for adults is also the responsibility of the MC+ health plan.

The MC+ health plans will be responsible for transportation for services covered by the MC+ program. Transportation covered in the MRDD waiver is limited to waiver-covered services.

TRANSITION OF EXPANDED SERVICES TO WESTERN MC+ REGION

Adult Day Health Care/Personal Care Services

Health plans are responsible for the continuation of services for MC+ enrollees receiving adult day health care services and/or basic or advanced personal care services. The Division of Medical Services (DMS) will notify health plans of enrollees who are receiving these services at the time of enrollment or shortly thereafter to facilitate the transition to health plan benefits and providers.

Individuals receiving these services have been assessed by the Division of Aging at a nursing home level of care. Individuals assessed by the Division of Aging as eligible for these services must continue to receive them from their MC+ health plan.

Dental Services

Dental services, with the exception of orthodontics, for adults age 21 and over who have received prior authorization from DMS before the recipient's enrollment effective date will be reimbursed for the prior authorized services on a fee-for-service basis by DMS.

Optical Services

Optical services for special frames that have been prior approved by DMS before enrollment in a health plan for MC+ enrollees age 21 and over will be reimbursed on a fee-for-service basis by DMS for the prior authorized services.

Hearing Aids

Hearing aids and related services that have been prior approved by DMS for MC+ enrollees age 21 and over before enrollment in a health plan will be reimbursed on a fee-for-service basis by DMS for the prior authorized services.

ADULT COVERAGE FOR BEHAVIORAL HEALTH SERVICES

The 30/20 benefit limitation for adult* behavioral health services has been removed from the MC+ Western Region contract only, effective February 1, 1999. All medically necessary behavioral health services included in the benefit package will be the financial responsibility of the MC+ health plans.

Services provided by a Community Psychiatric Rehabilitation (CPR) provider will be reimbursed by DMS on a fee-for-service basis according to the terms and conditions of the Medicaid fee-for-service program.

* Coverage limitations for adult behavioral health services are effective for certain eligibility groups. Refer to Special Bulletin Vol. 21, No. 4, dated January 22, 1999.

THIRD PARTY LIABILITY FOR WESTERN MC+ REGION

Effective February 1, 1999, MC+ health plans are responsible for performing Third Party Liability (TPL) activities for eligibles with private health insurance coverage enrolled in their health plan. TPL recoveries are delegated to the MC+ health plans. Included in the Western MC+ Region are the counties listed on Page 2 of this bulletin.
By law, Medicaid is the payor of last resort. This means that the MC+ health plans contracted with the State will assume the "payer of last resort" status and shall be used as the source of payment only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and postpayment recovery (i.e., Pay and Chase).

The MC+ health plan shall cost avoid all claims or services that are subject to payment from a commercial third party health insurance carrier. If a commercial third party health insurance

carrier requires the member to pay any cost-sharing, the MC+ health plan is responsible for paying the cost-sharing, even to a non-contracted provider. The health plan's liability for such cost-sharing amounts shall not exceed the amount the health plan would have paid under the health plan's payment schedule.

If a claim is cost-avoided, the establishment of liability takes place when the health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability.

If the probable existence of third party coverage cannot be established or third party benefits are not available at the time the claim is filed, the MC+ health plan must pay the full amount allowed under the health plan's payment schedule.

The requirement to cost avoid applies to all covered services except claims for labor and delivery and postpartum care; prenatal care for pregnant women; preventative pediatric services; or if the claim is for a service provided to a member on whose behalf child support enforcement is in effect. The MC+ health plan is required to provide such services and then recover payment from the third party health insurance carrier (Pay and Chase).

During the first year of this contract, the MC+ health plan shall not deny claims or pursue reimbursement in the following circumstances:

Worker's Compensation
Tortfeasors
Motorist Insurance
Liability/Casualty Insurance
Estate Recovery

This will change for the second year of the contract. More information will follow at a future date. DMS shall pursue reimbursement in such cases and the MC+ health plan shall immediately report any cases involving the above circumstances to DMS. If the MC+ health plan or any of its subcontractors receive reimbursement as a result of such situations, that payment must be forwarded to DMS immediately upon receipt.

IMPORTANT: Contact the Division of Medical Services, Third Party Liability Unit, at 573/751-2005 if you have any questions.